

EINHORN (Max)

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[Reprinted from THE POST-GRADUATE, Vol. VIII., No. 2, 1893.]



NEW YORK:
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ENTEROPTOSIS, OR GLENARD'S DISEASE.¹

IN consequence of the advances in bacteriology, the greatest amount of scientific work is being devoted to the micro-organisms, but the mechanical conditions which play an important rôle in generating and maintaining some diseases should not be overlooked. The majority of writers on the digestive tract, during recent years, have devoted themselves to the consideration of the chemical functions of the stomach, but Glénard's subject was the anatomy of the whole region concerned in the processes of digestion, and the mechanical disturbances which may be produced by pathological abnormalities.

The importance of Glénard's work² in understanding and treating stomach troubles made it, in my opinion, sufficiently interesting for discussion this evening.

The idea which led the French physician to the discovery of the disease designated by his name, was the fact that the whole digestive tract, which from the mouth to the anus is ten or fifteen times longer than a straight line connecting both points, is arranged in the form of different baldachins suspended on six loops³ by means of ligaments at the posterior wall of the abdomen.

The zigzag direction of the loops offers the possibility of too great a bend, sometimes at such an acute angle that it causes obstruction to the passage of the ingesta or secretion at the six main points of fixation. This might occur at the gastroduodenal, duodenojejunal, the transverse,⁴ and the sigmoido-rectal curvatures.

¹ Read before the New York Post-Graduate Clinical Society, December 3d, 1892.

² F. Glénard, *Lyon Médical*, 1885, t. xlviii., p. 450.

³ 1. Anse gastrique. 2. Anse duodénale. 3. Anse iléocolique. 4. Anse colique transverse. 4 a. Costosoupylorique. 5 c. Sous-pylori-costale. 6. Anse colosigmoidale.

⁴ "Colique sous costal droit," "colique sous-costal] gauche," "sous-pylorique du transverse."

The ligaments are not all of equal strength, and the points of fixation of several of them are especially weak. This is true of the gastroduodenal and the transverse colon ligaments. Thus, from a theoretical point of view, it is apparent that under favorable conditions the possibility exists that the weak ligaments may give way, and that a falling of that part of the intestine may result. This would naturally exert increased traction on the next fixation point, and might cause an obstruction to the passage of the contents of the intestine, or, in other words, a partial enterostenosis. In forty autopsies Glénard several times found the colon transversum displaced and stenosed. He recognized that these changes in the anatomical position must give rise to troubles, which should be considered dependent upon this condition. In examining all his patients with digestive troubles, he found that there were many so-called "nervous dyspeptics" in whom he could discover by a thorough investigation of the abdomen that some abnormal position of the intestines existed. He described the following conditions:

1. Splashing sound (*clapotement epigastrique*).
2. Pulsation of the abdominal aorta (*battement aortique*).
3. "Corde colique transverse."
4. In the right hypochondriac region frequently movable kidney.

Under "corde colique transverse" Glénard means that resistance which is found lying over the aorta three to five centimetres above the navel, running horizontally six to ten centimetres on each side of the median line. This gives the impression of a ribbon one centimetre in width, and was supposed by Glénard to be the displaced colon transversum, for pressure on the right iliac region at the beginning of the colon ascendens produced rumbling sounds in the corde transverse. He consequently concluded that all the symptoms in these patients were caused by this abnormal position of the intestine. He named this condition "enteroptosis."

This disease begins with a prolapse of the intestines, particularly of the right part of the colon transversum, due to a relaxation of the weak ligamentum colico-hepaticum. The colon ascendens and colon transversum, losing their ligamentous suspension, sink down, and so the colon transversum, instead of running straight across the abdominal cavity, runs obliquely from below upward. At the left end the transverse colon is held in place by the strong ligamentum gastro-colicum. The acute angle produced at this point by the prolapse of the other end of the transverse colon

causes a partial occlusion of the lumen of the gut (enterostenosis). The transverse colon, therefore, remains contracted and empty, and gives the condition described as "corde transverse." Coincident with the descent of the transverse colon there is a relaxation of the ligaments (mésenteris) of the small intestines, and this produces a dragging down of the stomach, and causes the liver and kidney, through the ligamentum gastro-colicum, to assume a lower position than normal (hepatoptosis and nephroptosis). Thus there may be a prolapse of all the intestines—splanchnoptosis. This enteroptosis causes enterostenosis and increases the specific gravity of the intestines, because they do not contain gas, thus diminishing the abdominal tension. A *circulus vitiosus* is produced which, if not interfered with, grows worse.

The subjective symptoms of this disease are: weakness and a constant feeling of lassitude; difficulty in digestion of fats, farinaceous food, acids, pure wine, pure milk, with an increase in the digestive troubles about three hours after meals; sleeplessness; usually constipation or irregularity of the bowels.

The objective conditions are: decreased tension of the abdomen; prolapsus of the abdominal intestines (enteroptosis, gastroptosis, frequently movable kidney, movable liver); enterostenosis.

Glénard distinguishes three different periods of the disease—1, Atonie gastrique par entéroptose; 2, Mésogastrique, gastroptose; 3, Neurasthénique, entérostenose—and describes them as follows:

During the first period of the disease (atonie gastrique par entéroptose) the patient eats everything, but experiences slight somnolence or a burning sensation after meals; about 2 o'clock A.M. the sleep is interrupted for a few minutes. Generally there is one evacuation of the bowels in the morning, of somewhat diarrhœic nature; there is a gradual loss of strength.

In the second period (mésogastrique, gastroptose) the patient avoids fat, farinaceous food, acids, milk, wine; complains of a sensation of dragging, false hunger, and emptiness about three hours after meals. About 2 o'clock A.M. he remains awake for about two to three hours; suffers from constipation, interrupted once in a while by diarrhœic evacuations; always feels tired, particularly when arising and about 3 o'clock in the afternoon.

In the third period (neurasthénique, entérostenose) the patient has lost about thirty to forty pounds and is not sufficiently nourished; he has lived on milk diet, on purées, beef tea—on most improbable meals; complains of a weighty sensation or cramps in the stomach, and is almost constantly suffering. He does not sleep; the constipation is most obstinate; the daily enemata with

difficulty effect an evacuation of fatty scybala surrounded by mucus or pseudo-membranes from time to time. There is constant complaint of great weakness, so that he hardly leaves the room, and lies on the lounge constantly. He represents the most varied nervous symptoms: cerebral, spinal, sympathetic, both psychical and physical.

As this whole series of symptoms is caused and explained (1) by enteroptosis, (2) enterostenosis, (3) deficient nutrition, the fundamental indications for the successful treatment are pointed out by Glénard in the following way:

1. The intestines have to be raised and maintained in their position.
2. The abdominal tension must be increased.
3. The bowels have to be regulated.
4. The secretions of the digestive tract and of the annexed glands have to be stimulated.
5. The alimentation has to be regulated and the digestion assisted.
6. The organism has to be stimulated.

The first two points are accomplished by wearing an abdominal bandage reaching to the navel and exerting a pressure upon the hypogastrium from below upward. This bandage raises the intestines and increases the tension of the abdomen.

In order to regulate the bowels Glénard gives his patients, a quarter of an hour before breakfast, natrium sulphate 4.0, magnesia sulphate 3.0, in half a glassful of water; or half a glass of Janos; or one-quarter of a glass of Rubinat; or a teaspoonful Carlsbad salt; or pills consisting of 0.05 aloes or 0.05 extractum rhei. The fourth requirement must be accomplished by massage, electricity, and lavage of the stomach; and the sixth, by gymnastic exercises.

As to alimentation Glénard has given the following table:

During the first stage of the disease.—Boiled meat, roast game, odorless squabs, brain; farinaceous vegetables (lentils, potatoes), rice, carrots; grapes, very ripe fruit; fried eggs, oysters, liver (fat); Gerx and Gruyère cheese; red wine diluted with water; sauces, juices, lards, fries, Italian pâtés, salad; pure red wine, creams, undiluted boiled milk, fresh milk.

Second stage of the disease.—Roast meat (beef, mutton, veal, chicken), lean ham; fish, sole, white fish, trout, wolf; scrambled eggs; fresh vegetables, well cooked, English style; cheeses (Brie,

¹ C. A. Ewald, Berliner klinische Wochenschrift, 1890, p. 277.

Camembert); baked apples, preserves, compotes; chocolate, beer, cider (?), white wine (?).

Third stage of the disease.—Raw meat (beef, mutton), raw eggs, stale bread, coffee with milk (one-third milk, two-thirds coffee); coffee, tea, water, water with cognac, champagne; broiled meat (roast beef, mutton, lamb chops, tenderloin of beef); eggs, bouillon, preserves.

Under this treatment Glénard was always able either to effect a cure or an amelioration and subsidence of the symptoms. The successful result of his treatment, based upon the theory of enteroptosis, Glénard considers as a proof of veracity and accuracy of the conception of the new disease.

After having given a description of enteroptosis based on the views of Glénard, it is important to reflect whether the objective points given by this author should be understood in the way he interpreted them. Ewald,¹ who first described "Glénard's disease" in Germany, is of the opinion that the "corde colique transverse" is in reality the pancreas. The *clapotement*, or splashing sound of the stomach, found two to six hours after meals—one of the other objective points—appears in many other conditions of stomach derangements and is by no means characteristic of enteroptosis. The best and surest way to recognize enteroptosis is to find out the exact position of the stomach. Ewald has laid much stress on this point. He inflates the stomach with air, and, finding the small curvature of the stomach below the ensiform process or midway between it and the navel, he concludes that "gastroptosis" is present, and then the diagnosis of general "enteroptosis" is justified.

In order to recognize the position of the stomach, one can make use of "gastrodiaphany,"¹ and I had the opportunity of presenting a case of enteroptosis at the last September meeting of German Physicians, where the stomach (small curvature) was situated below the umbilicus and reached the symphysis pubis. I have observed several similar cases in which the small curvature of the stomach was situated, according to the result of "diaphany," either in the navel line or one to two finger widths above the navel; but these cases must be considered as the highest degrees of "gastroptosis."

The frequency of Glénard's disease will depend upon the means employed in the diagnosis of "enteroptosis." If the diagnosis is made only in those cases where a real "gastroptosis" is found,

¹ M. Einhorn on Gastrodiaphany, New York Medical Journal, December 3d, 1892.

the percentage will be small; otherwise it will be quite large. Among thirteen hundred patients with digestive troubles Glénard found four hundred with "enteroptosis." Among these four hundred, one hundred and forty-eight had also a movable kidney (entero-nephroptosis) and nineteen had movable liver (entero-hepatoptosis). Ewald estimated the number of enteroptoses among his patients at about thirteen per cent.

According to my experience Glénard's disease appears quite frequently. Among my private patients of last October there were forty suffering from digestive troubles, and ten of them belonged to the class which Glénard designates "enteroptosis." In all of them I could palpate the right kidney, but in four only was I able to feel the whole kidney, whereas in the other six the lower margin of the kidney could be felt during inspiration. Among these ten patients, in three I found the small curvature of the stomach situated very low—real "gastroptosis."

I agree with Glénard in regard to the bandage which should support and elevate the intestines, but the medicinal and dietetic treatment must be made dependent upon the result of a chemical analysis of the stomach contents. For, according to my experience, the chemical condition of the stomach in these cases of "enteroptosis" is not always alike. In those cases where there is hyperacidity—which is the case with the greater number of this class of patients—Glénard's rules are excellent; but where there is an insufficiency or a lack of HCl, the treatment will have to be modified.

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